MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

[redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (163-G)

[redacted] Registered No.

09083

1. PLACE OF DEATH:
(a) ~~Baltimore City,~~ Maryland
(b) Street address Elkridge Howard Co. Md.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elkridge
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruby Beecraft

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 24, 1930

8. AGE: Years 15 Months 5 Days 23 If less than one day hr. min.

9. Birthplace Daisy, Howard Co. Md.
(Town, county, and state)

10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Raymond Beacraft
13. Birthplace Florence, Howard Co. Md.

MOTHER
14. Maiden Name Sylvia Poole
15. Birthplace Florence Howard Co. Md.

16 (a) Informant Md. Childrens Aid Society Inc.
(b) Address 2133 Maryland Ave. Balto.

17 (a) Burial (b) Date thereof Sept. 19, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Howard Chapel Cem.
Location Long Corner, Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

19 (a) Filed 1945 (b) Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1945, at 6:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Toxic hepatitis, due to phosphorus poisoning; probably suicide.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept. 16 1945

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. 19684
Registrar's No. 131

State of Maryland

1. PLACE OF DEATH:
(a) County HOWARD
(b) ~~City or town~~ Poplar Springs, Road (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: —
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution —
In this community — (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ky (b) County
(c) ~~City or town~~ Sinai (If outside city or town limits, write RURAL)
(d) Street No. Route #2 (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) FULL NAME COFFEY, Robert E.
3. (b) If veteran, name war World II
3. (c) Social Security No. 400205780
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced —
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased February 21, 1921 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
24	6	16	hr. min.

9. Birthplace CALVISA, Ky (City, town, or county) (State or foreign country)
10. Usual occupation —
11. Industry or business —
MOTHER FATHER
12. Name Ernest Coffey
13. Birthplace — (City, town, or county) (State or foreign country)
14. Maiden name —
15. Birthplace — (City, town, or county) (State or foreign country)

16. (a) Informant's own signature
(b) Address
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 10, 1945 (Month) (Day) (Year)
(c) Place; burial or cremation Removal to Laurenceburg-Ky.
18. (a) Signature of funeral director M. L. Creagan
(b) Address Thurmont Md
19. (a) 10-Sept-1945 (Date received by local registrar) (b) Elizabeth G. Heck. (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month Sept day 7
year 1945 hour 1230 minute —
21. I hereby certify that I attended the deceased from , 19 , to , 19 :
that I last saw h alive on , 19 :
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Fracture skull	
Shock	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

PHYSICIAN

Major findings:
Of operations
Of autopsy

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 7 Sept 45
(c) Where did injury occur? Poplar Springs, Howard, Md (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? Poplar Springs Road (Specify type of place)
While at work? (e) Means of injury Auto acci-
23. Signature P. W. Barr (M. D. or other) dent
Address Date signed

8-6917 U. S. GOVERNMENT PRINTING OFFICE 16—13493

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

19085

Reg. Dist. No. 19-1

1. PLACE OF DEATH:

County: Howard

City or town: Glenelg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Clarksville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Arthur Alexander Dorsey

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	married

6.(b) Name of husband or wife: Emma Dorsey

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 28 1880

8. AGE: Years	Months	Days	If less than one day
65	4	1	hrs. min.

9. Birthplace: Mary Land.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Remus Dorsey
13. Birthplace: Md

MOTHER
14. Maiden name: Alice Bentley
15. Birthplace: Md.

16. Informant: Mrs C. Dorsey
Address: Clarksville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 2, 1945 (month) (day) (year)

Cemetery or crematory: Locust Chapel

Location: Ashton Md.

18. Funeral director: T.C. Deginbottom

Address: Ellicott City Md.

19. Oct 2, 1945 (Date rec'd by registrar) John B. Lynchan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/29 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/29 1945 to 9/29 1945 and that I last saw him alive on no date 19

Immediate cause of death	DURATION
Coronary Thrombosis	instant
Due to Arteriosclerotic Vascular Disease	1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: George E. Bunting M.D.
DEPUTY MEDICAL EXAMINER FOR Howard Co.

Address: Ellicott City Md. Date signed: 10/1/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

09086 / 95
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: County Howard; City or town ~~Life~~ Laurel — Rural
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Scaggsville
Stay in hospital or inst. (yrs., or mos., or days) Life.
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard
City or town ~~Rural~~ Laurel Ward No. Rural
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Scaggsville
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Thomas Dustin

3. (b) Social Security Number

4. Sex: Male | 5. Color or race: White | 6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Christine Lackey Dustin
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 29 - 1879

8. AGE: Years 66 | Months | Days 8 | If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Silas R. Dustin
13. Birthplace Md

MOTHER 14. Maiden name Mary Stuty
15. Birthplace Md

16. Informant Mrs Christine Dustin
Address Laurel R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 8 45
(month) (day) (year)

Cemetery or crematory St Mary's
Location Laurel Md

18. Funeral director Lloyd Hauser
Address Laurel Md

19. 9/8/45 (Date rec'd by registrar) 19 Frank Thayer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1945, at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 1945, to Sept 6 1945, and that I last saw him alive on Sept 6 1945.

	DURATION
Immediate cause of death: Acute pneumonia	6 days
Due to	
Due to	
Other conditions: Coronary thrombosis	3 1/2 yrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert S McCreary M.D.
M. D. or other
Address Laurel Md Date signed 9/7/45

STATE OF MARYLAND—CERTIFICATE OF DEATH

09087

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Howard — Registration Dist. No. 193

Village or City Glenwood — No. — St., — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S. if of foreign birth? — yrs. — mos. — ds.

2. FULL NAME Charles Gaither — If U. S. Veteran, specify WAR —

(a) Residence: No. Glenwood St., — Ward. —

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	C	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, and year) Sept 12 1940

7. AGE Years	Months	Days	If LESS than 1 day, — hrs. or — min.
		4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Glenwood Md

FATHER

13. NAME John Gaither

14. BIRTHPLACE (city or town) (State or country) Howard Co Md

MOTHER

15. MAIDEN NAME Florence Mehrs

16. BIRTHPLACE (city or town) (State or country) Glenwood Md

17. INFORMANT John Gaither (Address) Glenwood Md

18. BURIAL, CREMATION, OR REMOVAL Place Howard Cha[illegible] Date Sept 16, 1940

19. UNDERTAKER None (Address)

20. FILED Sept 16, 1940 E. Boyd Mercer Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Sept (Month) 16 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Sept 12, 1940 to Sept 16, 1940

t lest saw him alive on Sept 14, 1940; death is said to have occurred on the date stated above, at 3 — m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Enlarged Tonsils	

Other Contributory Causes of importance:

Name of operation — Date of —

What test confirmed diagnosis? — Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of Injury —, 19—

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? —

If so, specify —

(Signed) S. A. Nichols M. D.

(Address) Clarksville Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3d)

09088

CERTIFICATE OF DEATH

Reg. Diat. No. 190

1. PLACE OF DEATH:
County: Howard
City or town: Elkridge - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month.
Hospital, institution, or street address where death occurred: Balto.-Wash Blvd - near Dorsey Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1806 Hennenman Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Herrmann

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widow.

6.(b) Name of husband or wife: Fread. Herrmann

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 8th 1876

8. AGE: Years 69 | Months 7 | Days 20 | If less than one day ..... hrs. ..... min.

9. Birthplace: Balto. City, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Unknown.
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Mr. Louis Cooney
Address: Elkridge 27, Md.

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 10/1/45 (month) (day) (year)
Cemetery or crematory: Holly Redeemer
Location: Baltimore Co. Balto., Md.

18. Funeral director: Leo L. Leach
Address: 1701-03 N. Patterson Park Ave

19. Sept 28 45 (Date rec'd by registrar) (Miss) E. Bird Miller Registrar Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28th 1945 at 1 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 28 1945, to Sept. 28 1945 and that I last saw h. alive on Sept. 28 1945

Immediate cause of death	DURATION
Cardiac Asthma	1 hr.
Due to: Hypertensive-Cardio-Vascular Disease	?
Due to: Arteriosclerosis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ✓

Date of op.

Autopsy results: ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank Shipley M.D.
M. D. or other
Address: Savage, Md. Date signed 9/29/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1700)

CERTIFICATE OF DEATH

09089

Reg. Diat. No.

P

1. PLACE OF DEATH:
County: Howard
City or town: Folly Quarter-Ellicott City, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Weeks
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Folly Quarter-Ellicott City, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Gerard Joseph Jucha O.M.C.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 3rd 1923

8. AGE: Years	Months	Days	If less than one day
22	6	17	hrs. min.

9. Birthplace: Shamokin, Pa. (Town, county, and state)
10. Usual occupation: Student
11. Industry or business: Franciscan Seminary
FATHER 12. Name: Adalbert Jucha
13. Birthplace: ?
MOTHER 14. Maiden name: Laura Chaplewska
15. Birthplace: ?
16. Informant: Rev. Daniel Balcerak O.M.C.
Address: Ellicott City, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 9-25-45 (mouth) (day) (year)
Cemetery or crematory:
Location: Shamokin, Pa.
18. Funeral director: George A. Weber
Address: 705 South Ann Street
19. 9-21 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/20 1945 at 1:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/20 1945 to 9/20 1945 and that I last saw h. alive on no date 19

Immediate cause of death	DURATION
fracture of skull at base	instant
Due to	
Due to	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 9/20/45
Where did injury occur? N. Ellicott City (City or town) Howard (County) Md. (State)
Injured at home, farm, industry, public place (where?): Franciscan Seminary
Means of injury: jumped from moving truck Injured at work? yes

23. SIGNATURE: George E. Burgtorf M.D.
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other
Address: Ellicott City, Md. Date signed: 9/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (100)

09090

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County Howard Maryland
City or town Poplar Springs - Route 40
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? -
Hospital, Institution, or street address where death occurred:
Route 40 Poplar Springs, Md.
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Texas County -
City or town Comanche
(If outside city or town limits, write RURAL and give nearest town)
Street No. -
(If rural, give LOCATION)
2.(a) If veteran, name war -

3. (a) FULL NAME Robert Joseph Magness

3. (b) Social Security Number -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife -
6.(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) November 28, 1921

8. AGE:

Years	Months	Days	If less than one day
23	9	9	- hrs. - min.

9. Birthplace Comanche, Texas
(Town, county, and state)
10. Usual occupation Soldier
11. Industry or business U. S. Army
FATHER 12. Name Unknown
13. Birthplace Unknown
MOTHER 14. Maiden name Maude (unknown) Magness
15. Birthplace Unknown
16. Informant Service Record
Address U. S. Army
17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept 8. 1945 (month) (day) (year)
Cemetery or crematory Comanche Funeral Home.
Location Comanche, Texas.
18. Funeral director Howard M. Blight Jr.
Address 4914 Belair Road, Baltimore, Md.
19. September 8 1945 (Date rec'd by registrar) Frank J. Tollison (Registrar) MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1945 at 11 55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/6 1945, to 9/6 1945
and that I last saw him alive on no date 1945

Immediate cause of death	DURATION
Compound Fracture of skull at base, occipat and Frontal region	instant
Due to	
Due to	
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operations none
Date of op. -
Autopsy results XXXXXX As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 9/6/45
Where did injury occur? Poplar Springs (City or town) Howard (County) Md. (State)
Injured at home, farm, industry, public place (where?) Public Rd. Route #40
Means of injury Auto ran into tree Injured at work? no

23. SIGNATURE George E. Burtoft M.D.
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other
Address Ellicott City Date signed 9-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

09091

Reg. Dist. No. 191

1. PLACE OF DEATH:

County: Howard

City or town: Columbia Rd, Ellicott City
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs Md

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Ellicott City, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Columbia Road
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mathilde Barbara Mann

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Howard Mann

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar. 5, 1884

8. AGE:

Years	Months	Days	If less than one day
61	6	16	..... hrs. ..... min.

9. Birthplace: Baltimore Balto. Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Alexander Steinberg
13. Birthplace: Germany

MOTHER
14. Maiden name: Elizabeth Wiegand
15. Birthplace: Germany

16. Informant: Howard Mann
Address: Ellicott City, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 22 1945 (month) (day) (year)

Cemetery or crematory: Lorraine Park Cem.

Location: Baltimore Co. Md.

18. Funeral director: Easton Sons Md.

Address: 608 Frederick Ave. Catons.

19. Sept. 22 1945 (Date rec'd by registrar) John B. Leughman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 21, 1945 at 2:45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 18 1944 to Sept. 21 1945 and that I last saw her alive on Sept 16 1945

	DURATION
Immediate cause of death: Carcinomatosis	
Due to: Cancer of Sigmoid	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Excision of sigmoid and growth Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Rena S. Abercrombie M.D.
M. D. or Other

Address: 3524 Greenmount Ave Date signed: Sept. 24, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

19092

Reg. Dist. No. 191

1. PLACE OF DEATH:

County Howard

City or town Elkridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Elkridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Martha A O'Donnell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Edw. L O'Donnell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 25, 1871

8. AGE: Years	Months	Days	If less than one day
74	1	16	..... hrs. ..... min.

9. Birthplace Mary Land (Town, county, and state)

10. Usual occupation at home

11. Industry or business -

FATHER 12. Name Henry Dennead

13. Birthplace Md

MOTHER 14. Maiden name Mary Lyddane

15. Birthplace Md.

16. Informant Edw. L O'Donnell

Address Ellicott City Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-14-1945 (month) (day) (year)

Cemetery or crematory St Louis

Location Clarksville, Md

18. Funeral director J C Higinbotham

Address Ellicott City Md.

19. Sept 14 1945 (Date rec'd by registrar) John B. Loughran Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1945 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1- 1 1945, to 9/11 1945

and that I last saw her alive on 9/11/45 1945

Immediate cause of death	DURATION
Arteria Sclerotic Cardio-Vascular Disease	8 mo
Due to	
Due to	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. Burgtorf M.D. M. D. or other

Address Ellicott City, Md Date signed 9/13/45

(M)

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

09093

Reg. Diat. No. 191

1. PLACE OF DEATH:

County: Howard

City or town: Clarksville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Howard

City or town: Clarksville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Catherine Spicer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Garnett Spicer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 18, 1899

8. AGE: Years	Months	Days	If less than one day
45	11	11	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER — 12. Name: Walter Brooks

13. Birthplace: Va

MOTHER — 14. Maiden name: Fannie Cassell

15. Birthplace: Va

16. Informant: Garnett Spicer

Address: Clarksville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-3 1945 (month) (day) (year)

Cemetery or crematory: Lutheran Chapel

Location: Clarksville, Md

16. Funeral director: H. C. Nyumbrathom

Address: Elkott City, Md

19. Oct 3, 1945 (Date rec'd by registrar) John B. Langhan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-29 1945 at 10.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-28 1945 to 9-29 1945 and that I last saw her alive on 9-28 1945

Immediate cause of death	DURATION
Pul. Tbc.	3 days
	2 yrs?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. B. Warren M. D. or other

Address: Laurel Md Date signed: 9-29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BD)

CERTIFICATE OF DEATH

090 94

Reg. Dist. No. 191

1. PLACE OF DEATH:

County Howard

City or town Daniels

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Va. County

City or town Front Royal

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Frank Talbert

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife Mary E Talbert

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1860

8. AGE: Years	Months	Days	If less than one day
85	7	9	hrs. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name unknown

13. Birthplace "

MOTHER 14. Maiden name "

15. Birthplace "

16. Informant Wm Talbert

Address Daniels Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-26-45 (month) (day) (year)

Cemetery or crematory Prospect Hill

Location Front Royal Va.

18. Funeral director F C Hiz undertaker

Address Emmett City Md

19. Sept. 24 1945 John B Langhran Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1945, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 17 1945, to Sept 24 1945

and that I last saw h... alive on Sept 24 1945

Immediate cause of death	DURATION
Arteriosclerotic C. V. Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Leon A. Kushman M.D.

M. D. or other

Address Edinburg Va Date signed 9/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15